WISCONSIN MEDICAID

DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services.

INSTRUCTIONS

Nonbilling providers receive nonbilling provider numbers. The numbers *cannot be used independently* to bill Wisconsin Medicaid. The following nonbilling providers are required to complete the Declaration of Supervision for Nonbilling Providers form for changes in physical address and all supervisor changes:

- Occupational Therapy Assistant.
- Physical Therapist Assistant.
- Physician Assistant.
- Speech Therapist, bachelor of arts level.

The nonbilling provider(s) who has changed his or her work address or supervisor should complete Section I. The nonbilling provider's supervisor should complete Section II.

SECTION I — PROVIDER INFORMATION

Name — Nonbilling Provider and Credentials
Enter the nonbilling provider's first name, middle initial, and last name. Also include whether the nonbilling provider is an occupational therapy assistant, physical therapist assistant, physician assistant, or speech therapist, BA level.

Wisconsin Medicaid Provider Number
Enter the nonbilling provider's eight-digit Medicaid identification number. Do not enter any other numbers or letters.

Address — Nonbilling Provider
Enter the nonbilling provider's complete physical work address (street, city, state, and ZIP code). A post office (P.O.) box number alone is *not* acceptable.

Telephone Number — Nonbilling Provider
Enter the nonbilling provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Provider Reimbursement Statement
In the space labeled "Name — Provider," write the complete name of the nonbilling provider. In the space labeled "Name — Clinic or Supervisor" write the name of the clinic or supervisor where Wisconsin Medicaid will send reimbursement.

Signature — Nonbilling Provider
The signature of the nonbilling provider is required here. Signature stamps and electronic signatures are not acceptable.

Date Signed
Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed. This is a required field.

SECTION II — SUPERVISOR INFORMATION

Name — Supervisor
Enter the supervisor's first name, middle initial, and last name.

Wisconsin Medicaid Provider Number
Enter the supervisor's eight-digit Medicaid identification number, if applicable. Do not enter any other numbers or letters.

IRS Number — Employer
Enter the nine-digit federal tax identification number (Internal Revenue Service [IRS] number) of the supervisor's employer.

Address — Supervisor
Enter the supervisor's complete physical work address (street, city, state, and ZIP code).

Telephone Number — Supervisor
Enter the supervisor's telephone number, including the area code, of the office, clinic, facility, or place of business.

Supervisor Reimbursement Statement
In the space labeled "Name — Supervisor," write the complete name of the nonbilling provider's supervisor. In the space labeled "Name — Provider," write the complete name of the nonbilling provider. In the space labeled "Supervisor's Effective Starting Date," enter the month, day, and year (in MM/DD/YYYY format) when this person began supervising the nonbilling provider's work.

Signature — Supervisor
The signature of the supervisor must appear here. Signature stamps and electronic signatures are not allowed.

Date Signed
Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed.

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1182 (Rev. 09/02)

WISCONSIN MEDICAID
DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS

SECTION I — PROVIDER INFORMATION

Name and Credentials — Nonbilling Provider	Wisconsin Medicaid Provider Number
Address — Nonbilling Provider	Telephone Number — Nonbilling Provider

I,_____, direct Wisconsin Medicaid to make checks payable to
(Name — Provider)

_____ for all claims payments for services performed by me
(Name — Clinic or Supervisor)

under Wisconsin Medicaid since Wisconsin Medicaid cannot reimburse me.

I understand that this payment arrangement will continue in effect until Wisconsin Medicaid receives a new Declaration of Supervision form from me. When my supervisor, employer, or work address changes, I will immediately send this completed form to Wisconsin Medicaid.

SIGNATURE — Nonbilling Provider (required)	Date Signed (required)

SECTION II — SUPERVISOR INFORMATION

Name — Supervisor	Wisconsin Medicaid Provider Number	IRS Number — Employer
Address — Supervisor		Telephone Number — Supervisor

I,_____, am supervising the work of_____.
(Name — Supervisor) (Name — Provider)

The effective starting date of my supervision was _____. I hereby acknowledge and
(Supervisor's Effective Starting Date)
agree to the above payment arrangement.

I understand that if my name is indicated in Section I above, Wisconsin Medicaid payment for services provided by the above provider will be payable to me directly and will be reported under the IRS number written above. If I discontinue supervision of the above provider, I understand that I must notify Wisconsin Medicaid at the address at the bottom of this page.

SIGNATURE — Supervisor	Date Signed

Mail to:
Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

For more information, contact Provider Services at (800) 947-9627 or (608) 221-9883.